TEXAS
Health and Human
Services Commission

	Date
Eligibility Worker	
Office Address and Telephone No.	

REQUEST FOR PATIENT TRUST FUND INFORMATION

(Please provide the following information and return this form in the envelope provided.)

Has _____ had a patient trust fund within the last six months?..... ☐ Yes ☐ No

If "**No**," please just sign the form at the bottom and return.

If "**Yes**," please provide the trust fund balance as of 12:01 a.m. on the first day of the month(s) listed at the right:

MONTH AND YEAR	AMOUNT
	$
	$
	$
	$

Also, please give the amount of interest earned for the month(s) listed here:

MONTH AND YEAR	AMT. OF INTEREST
	$
	$
	$
	$
	$
	$

VERIFIED BY: **X** _____ _____

Signature Date

PLEASE RETURN THIS FORM IN THE ENVELOPE PROVIDED